FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0038745

Facility Name: FAIRVIEW NURSING HOME, INC.

Address: 701 NORTH LAGRANGE ROAD (Number) LAGRANGE PARK (City) 60525 (Zip Code)

County: COOK

Telephone Number: (847) 354-7300 **Fax #** (847) 354-8928

IDPA ID Number: 36-3874603

Date of Initial License for Current Owners: 4/16/93

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	EDWARD N. SLACK, C.P.A
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,946	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,946	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	117		2,869	2,986	8
9	SNF/PED					9
10	ICF	29,195	10,653	1,579	41,427	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,312	10,653	4,448	44,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.63%

D. How many bed-hold days during this year were paid by Public Aid?
10 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/16/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/16/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,869

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	188,759	29,263	14,852	232,874		232,874	(3,347)	229,527			1
2	Food Purchase		164,126		164,126	(21,338)	142,788	954	143,742			2
3	Housekeeping	217,153	29,218		246,371		246,371	1,577	247,948			3
4	Laundry	76,354	16,056		92,410		92,410		92,410			4
5	Heat and Other Utilities			126,496	126,496		126,496	1,210	127,706			5
6	Maintenance	52,665		103,263	155,928		155,928	(791)	155,137			6
7	Other (specify):*							1,639	1,639			7
8	**TOTAL General Services**	534,931	238,663	244,611	1,018,205	(21,338)	996,867	1,242	998,109			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,698,436	76,293	228,959	2,003,688		2,003,688	(7,324)	1,996,364			10
10a	Therapy	75,991	1,126	9,708	86,825		86,825	(393)	86,432			10a
11	Activities	94,085	8,720	6,156	108,961		108,961	(2,332)	106,629			11
12	Social Services	52,441		4,709	57,150		57,150	(3,299)	53,851			12
13	Nurse Aide Training											13
14	Program Transportation			285	285		285		285			14
15	Other (specify):*							3,291	3,291			15
16	**TOTAL Health Care and Programs**	1,920,953	86,139	261,817	2,268,909		2,268,909	(10,058)	2,258,851			16
	C. General Administration											
17	Administrative	27,385		40,181	67,566		67,566	25,527	93,093			17
18	Directors Fees											18
19	Professional Services			221,176	221,176	(15,000)	206,176	(182,379)	23,797			19
20	Dues, Fees, Subscriptions & Promotions			82,105	82,105		82,105	(24,277)	57,828			20
21	Clerical & General Office Expenses	111,047	19,359	273,730	404,136		404,136	(156,369)	247,767			21
22	Employee Benefits & Payroll Taxes			425,124	425,124	21,338	446,462	(13,722)	432,739			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,790	6,790		6,790	3,490	10,280			24
25	Other Admin. Staff Transportation			3,241	3,241		3,241	(1,609)	1,632			25
26	Insurance-Prop.Liab.Malpractice			74,001	74,001		74,001	806	74,807			26
27	Other (specify):*							17,634	17,634			27
28	**TOTAL General Administration**	138,432	19,359	1,126,348	1,284,139	6,338	1,290,477	(330,899)	959,578			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,594,316	344,161	1,632,776	4,571,253	(15,000)	4,556,253	(339,715)	4,216,538			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

FAIRVIEW NURSING HOME, INC.
0038745
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	21,338	
2	FOOD		21,338

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	15,000	
19	PROFESSIONAL FEES		15,000

To reclass cost of appealing real estate taxes

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. #0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,310	56,310		56,310	150,507	206,817			30
31	Amortization of Pre-Op. & Org.			690	690		690	9,326	10,016			31
32	Interest			115,763	115,763		115,763	477,596	593,359			32
33	Real Estate Taxes			166,197	166,197	15,000	181,197	5,197	186,394			33
34	Rent-Facility & Grounds			597,687	597,687		597,687	(594,554)	3,133			34
35	Rent-Equipment & Vehicles			8,902	8,902		8,902	2,584	11,486			35
36	Other (specify):*											36
37	**TOTAL Ownership**			945,549	945,549	15,000	960,549	50,656	1,011,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	666	124,800	193,981	319,447		319,447	(2,271)	317,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,919	71,919		71,919		71,919			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	666	124,800	265,900	391,366		391,366	(2,271)	389,095			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,594,982	468,961	2,844,225	5,908,168		5,908,168	(291,330)	5,616,838			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(368)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,734)	30		9
10	Interest and Other Investment Income	(43,349)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(389)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(179)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(218,446)	21		24
25	Fund Raising, Advertising and Promotional	(10,917)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(100)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,216)	20		28
29	Other-Attach Schedule	(15,889)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (294,587)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	9,239		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 9,239		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (285,348)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRVIEW NURSING HOME, INC.

ID# 0038745

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Jury Duty Income	(155)	10	2
3	Miscellaneous Income	(100)	21	3
4	Collection Expense	(4,157)	21	4
5	Theft Loss	(271)	21	5
6	VA Expense	(11,648)	10	6
7	Non-Care Rental Income	462	34	7
8	Non-allowable Seminar Expense	(20)	24	8
9				9
10				10
11				11
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89				89
90	Total	(15,889)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,763	(4,782)		(2,329)						(3,347)	1
2	Food Purchase	(757)		(800)			2,511						954	2
3	Housekeeping			1,577									1,577	3
4	Laundry													4
5	Heat and Other Utilities			1,210									1,210	5
6	Maintenance		220	9,901	(10,923)		11						(791)	6
7	Other (specify):*			1,515			124						1,639	7
8	**TOTAL General Services**	(757)	220	17,166	(15,704)		317						1,242	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(11,803)		19,096	(9,781)		2		(4,838)				(7,324)	10
10a	Therapy			3,689	(4,082)								(393)	10a
11	Activities			1,600	(3,932)								(2,332)	11
12	Social Services			1,410	(4,709)								(3,299)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,291									3,291	15
16	**TOTAL Health Care and Programs**	(11,803)		29,086	(22,504)		2		(4,838)				(10,058)	16
	C. General Administration													
17	Administrative			25,462	(34,006)	34,006	65						25,527	17
18	Directors Fees													18
19	Professional Services		2,133	6,704	(191,235)		19						(182,379)	19
20	Fees, Subscriptions & Promotions	(13,312)		984	(11,954)		5						(24,277)	20
21	Clerical & General Office Expenses	(223,074)	8	90,682	(24,050)		65						(156,369)	21
22	Employee Benefits & Payroll Taxes				(13,722)								(13,722)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(20)		3,506			4						3,490	24
25	Other Admin. Staff Transportation			156	(1,878)		113						(1,609)	25
26	Insurance-Prop.Liab.Malpractice			806									806	26
27	Other (specify):*			13,397		4,237							17,634	27
28	**TOTAL General Administration**	(236,406)	2,141	141,697	(276,845)	38,243	271						(330,899)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(248,966)	2,361	187,949	(315,054)	38,243	590		(4,838)				(339,715)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,734)	144,781	8,460									150,507	30
31	Amortization of Pre-Op. & Org.		9,326										9,326	31
32	Interest	(43,349)	511,781	9,160			4						477,596	32
33	Real Estate Taxes		3,559	1,638									5,197	33
34	Rent-Facility & Grounds	462	(598,149)	3,133									(594,554)	34
35	Rent-Equipment & Vehicles			2,578			6						2,584	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(45,621)	71,298	24,969			10						50,656	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,271)						(2,271)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(2,271)						(2,271)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(294,587)	73,659	212,918	(315,054)	38,243	(1,671)		(4,838)				(291,330)	45

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		
				Fairview Healthcare Properties		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 597,687	Fairview Health Care Properties	100.00%	$	$ (597,687)	1
2	V	32	Interest Income		Fairview Health Care Properties	100.00%	(26,807)	(26,807)	2
3	V	32	Interest Expense		Fairview Health Care Properties	100.00%	538,588	538,588	3
4	V	21	Bank Charges		Fairview Health Care Properties	100.00%	8	8	4
5	V	33	Real Estate Tax		Fairview Health Care Properties	100.00%	3,559	3,559	5
6	V	31	Amortization		Fairview Health Care Properties	100.00%	9,326	9,326	6
7	V	30	Depreciation		Fairview Health Care Properties	100.00%	144,781	144,781	7
8	V	6	Repairs & Maintenance		Fairview Health Care Properties	100.00%	220	220	8
9	V	19	Consulting Fee		Fairview Health Care Properties	100.00%	2,133	2,133	9
10	V	34	Non-Care Rental Income		Fairview Health Care Properties	100.00%	(462)	(462)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 597,687			$ 671,346	$ * 73,659	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 3,763	$ 3,763	15
16	V	2	FOOD				(800)	(800)	16
17	V	3	HOUSEKEEPING				1,577	1,577	17
18	V	5	UTILITIES				1,210	1,210	18
19	V	6	REPAIRS AND MAINT.				9,901	9,901	19
20	V	7	EMP. BEN. - GEN. SERV.				1,515	1,515	20
21	V	10	NURSING				19,096	19,096	21
22	V	10A	THERAPY				3,689	3,689	22
23	V	11	ACTIVITIES				1,600	1,600	23
24	V	12	SOCIAL SERVICES				1,410	1,410	24
25	V	15	EMP. BEN. - HEALTHCARE				3,291	3,291	25
26	V	17	ADMINISTRATIVE				25,462	25,462	26
27	V	19	PROFESSIONAL FEES				6,704	6,704	27
28	V	20	DUES, SUBSCRIPTIONS				984	984	28
29	V	21	CLERICAL AND GENERAL				90,682	90,682	29
30	V	24	SEMINARS				3,506	3,506	30
31	V	25	AUTO EXPENSE				156	156	31
32	V	26	INSURANCE				806	806	32
33	V	27	EMP. BEN. - GEN. ADMIN.				13,397	13,397	33
34	V	30	DEPRECIATION				8,460	8,460	34
35	V	32	INTEREST	0			9,160	9,160	35
36	V	33	REAL ESTATE TAXES				1,638	1,638	36
37	V	34	BUILDING RENT - UNRELATED				3,133	3,133	37
38	V	35	EQUIPMENT RENTAL				2,578	2,578	38
39	Total			$			$ 212,918	$ * 212,918	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 4,782	0	100.00%	$ 0	$ (4,782)	15
16	V	19	ACCOUNTING	15,000			0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	15,720			0	(15,720)	17
18	V	19	BOOKEEPING	26,724			0	(26,724)	18
19	V	19	DATA PROCESSING	4,716			0	(4,716)	19
20	V	19	LEGAL	12,120			0	(12,120)	20
21	V	19	MANAGEMENT FEE	110,040			0	(110,040)	21
22	V	19	PROFESSIONAL FEES	6,915			0	(6,915)	22
23	V	20	ADVERTISING	11,954			0	(11,954)	23
24	V	25	REBILL BUS	1,878			0	(1,878)	24
25	V	0					0		25
26	V	22	HOME OFFICE PAYROLL TAX	13,722			0	(13,722)	26
27	V	1	REBILL. PAYROLL DIETARY	0			0		27
28	V	3	REBILL. PAYROLL HSKPNG	0			0		28
29	V	6	REBILL. PAYROLL MAINT.	10,923			0	(10,923)	29
30	V	10	REBILL. PAYROLL NURSING	9,781			0	(9,781)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,082			0	(4,082)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,932			0	(3,932)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	4,709			0	(4,709)	33
34	V	17	REBILL. PAYROLL ADMIN.	34,006			0	(34,006)	34
35	V	21	REBILL. PAYROLL CLERICAL	24,050			0	(24,050)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 315,054			$ 0	$ * (315,054)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	15	EMP. BEN HEALTHCARE				0		16
17	V	17	ADMINISTRATIVE				34,006	34,006	17
18	V	27	EMP. BEN GEN. ADMIN.				4,237	4,237	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 38,243	$ * 38,243	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 1,297	$ 1,297	15
16	V	2	FOOD				2,511	2,511	16
17	V	6	MAINTENANCE				11	11	17
18	V	7	EMP. BEN. - GEN. SERV.				124	124	18
19	V	10	NURSING				2	2	19
20	V	17	ADMINISTRATIVE				65	65	20
21	V	19	PROFESSIONAL FEES				19	19	21
22	V	20	DUES, FEES, SUB.				5	5	22
23	V	21	CLERICAL & GENERAL				65	65	23
24	V	24	SEMINARS				4	4	24
25	V	25	TRAVEL				113	113	25
26	V	32	INTEREST				4	4	26
27	V	35	RENT - EQUIPMENT & VEHICLES				6	6	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				85	85	28
29	V	1	DIETARY SUPP	3,626			0	(3,626)	29
30	V	39	ANCILLARY SUPP	2,356			0	(2,356)	30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,982			$ 4,311	$ * (1,671)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 25,507	$ 25,507	15
16	V									16
17	V									17
18	V									18
19	V	10	MEDICALSUPPLIES	30,345					(30,345)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			$ 30,345				$ 25,507	$ * (4,838)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 76,888	$ 76,888	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	76,888				(76,888)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 76,888			$ 76,888	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	26.81	see attached	1.44	2.00		$		1
2	Norm Goldberg	Owner	Administrative	0.34	see attached	1.47	2.94	salary alloc.	2,669	17-7	2
3	Jim Goodsite	Owner	Administrative	0.34	see attached	1.47	2.94	salary alloc.	3,823	17-7	3
4	Mark Steinberg	Relative	Administrative		see attached	1.47	2.94	salary alloc.	1,303	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,795		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	44,413	$ 3,763	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		44,413	(800)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	44,413	1,577	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		44,413	1,210	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	44,413	9,901	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		44,413	1,515	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	44,413	19,096	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	44,413	3,689	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	44,413	1,600	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	44,413	1,410	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		44,413	3,291	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	44,413	25,462	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		44,413	6,704	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		44,413	984	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	44,413	90,682	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		44,413	3,506	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		44,413	156	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		44,413	806	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		44,413	13,397	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		44,413	8,460	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		44,413	9,160	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		44,413	1,638	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		44,413	3,133	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		44,413	2,578	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 212,918	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		34,006	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			4,237	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 38,243	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	5,982	1,297	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		5,982	2,511	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		5,982	11	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		5,982	124	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		5,982	2	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		5,982	65	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		5,982	19	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		5,982	5	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		5,982	65	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		5,982	4	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		5,982	113	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		5,982	4	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		5,982	6	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		5,982	85	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 4,311	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 25,507	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 25,507	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 76,888	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 76,888	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/P Nomura		X	Mortgage			$ 5,906,356	$ 5,550,261			$ 504,827	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DIAWA		X	LINE OF CREDIT				1,468,128			114,619	6
7			X	INSURANCE FINANCE FEE							1,143	7
8												8
9	TOTAL Facility Related						$ 5,906,356	$ 7,018,389			$ 620,589	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(27,231)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (27,231)	14
15	TOTALS (line 9+line14)						$ 5,906,356	$ 7,018,389			$ 593,358	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income (Net)						$	$			$ (9,588)	1
2	Interest Income (Bldg. Co.)										(26,807)	2
3	Allocated from Care Center										9,164	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (27,231)	21

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	210,575	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	193,571	2
3. Under or (over) accrual (line 2 minus line 1).	$	(17,004)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	188,399	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	15,000	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	186,395	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	204,959	8
1996	200,280	9
1997	198,255	10
1998	200,541	11
1999	188,374	12

Fairview Nsg Home	188,375	2000 Accrual = 1999 RE Tax + 5%
Fairview HC Prop.	3,559	$188,375 x 105% = $197,794 - 9396 (Int. Inc. on Escrow Acct.)
Care Center Alloc.	1,638	
TOTAL	193,572	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 114,911
2. Number of Years Over Which it is Being Amortized: various
3. Current Period Amortization: 10,016
4. Dates Incurred: _____

Nature of Costs: Organization Costs, Loan Commitment Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility (Fairview HC Properties)		1994	$ 321,372	1
2	Allocation from Care Center			1,880	2
3	TOTALS			$ 323,252	3

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	131		1994		$ 4,323,143	$ 110,850	39	$ 110,850	$	$ 725,143	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	8,764	224	20	438	214	3,275	9
10	Various			1994	40,683	1,361	20	1,776	415	11,359	10
11	Various			1995	126,067	4,635	20	6,419	1,784	33,872	11
12	PLUMBING RENOV			1996	3,730	96	20	187	91	904	12
13	ELEVATOR RENOV			1996	2,587	66	20	129	63	613	13
14	PLUMBING RENOV			1996	1,936	50	20	97	47	461	14
15	ROOF RENOV			1996	26,100	669	20	1,305	636	6,199	15
16	PLUMBING RENOV			1996	759	19	20	38	19	187	16
17	PLUMBING RENOV			1996	1,847	47	20	92	45	452	17
18	PLUMBING RENOV			1996	1,221	31	20	61	30	300	18
19	ELECTRICAL RENOV			1996	782	20	20	39	19	192	19
20	ELEVATOR RENOV			1996	734	19	20	37	18	176	20
21	ELEVATOR RENOV			1996	796	20	20	40	20	200	21
22	WALL COVERINGS			1996	814	21	20	41	20	195	22
23	PLUMBING RENOV			1996	518	13	20	26	13	130	23
24											24
25	PAGE 12-1 REP TOTALS				43,764	1,162		1,435	273	5,855	25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				207,066	3,697		5,174	1,477	5,174	30
31	PAGE 12E TOTALS				48,881	8,065		2,035	(6,030)	2,119	31
32	PAGE 12D TOTALS				39,947	1,330		1,998	668	3,067	32
33	PAGE 12C TOTALS				72,608	2,089		3,633	1,544	8,432	33
34	PAGE 12B TOTALS				134,541	3,450		6,727	3,277	17,664	34
35	PAGE 12A TOTALS				55,368	1,621		2,770	1,149	11,394	35
36	TOTAL (lines 4 thru 35)				$ 5,142,656	$ 139,555		$ 145,347	$ 5,792	$ 837,363	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING RENOV			1996	2,687	69	20	134	65	570	9
10	HVAC RERNOVATION			1996	1,263	32	20	63	31	284	10
11	ELEVATOR RENOV			1996	17,696	454	20	885	431	4,277	11
12	COOLER RENOV			1996	659	76	20	33	(43)	159	12
13	HVAC RENOVATION			1996	927	24	20	46	22	207	13
14	PLUMBING RENOV			1996	792	20	20	40	20	167	14
15	PLUMBING RENOV			1996	687	18	20	34	16	159	15
16	HVAC RENOV			1996	851	22	20	43	21	190	16
17	ELECTRICAL RENOV			1996	547	14	20	27	13	119	17
18	ALARM RENOVATION			1996	1,220	31	20	61	30	275	18
19	HVAC RENOVATION			1996	845	22	20	42	20	189	19
20	ELEVATOR RENOV			1996	851	22	20	43	21	197	20
21	BOOSTER MOTOR			1996	1,593	183	20	80	(103)	400	21
22	PRINTING & DECOR			1997	2,515	64	20	126	62	483	22
23	PAINTING & DECOR			1997	663	17	20	33	16	116	23
24	BUILDING RENOV			1997	647	17	20	32	15	123	24
25	PLUMBING RENOV			1997	1,100	28	20	55	27	211	25
26	PLUMBING RENOV			1997	1,773	45	20	89	44	312	26
27	HVAC RENOVATION			1997	726	19	20	36	17	141	27
28	PLUMBING RENOV			1997	2,240	57	20	112	55	355	28
29	PLUMBING RENOV			1997	850	22	20	43	21	133	29
30	HVAC RENOV			1997	655	17	20	33	16	102	30
31	ELEVATOR DOOR			1997	584	15	20	29	14	89	31
32	STEEL DOORS			1997	2,794	72	20	140	68	478	32
33	ELECTRICAL RENOV			1997	938	24	20	47	23	161	33
34	HVAC RENOV			1997	6,294	161	20	315	154	1,050	34
35	PLUMBING RENOV.			1998	2,971	76	20	149	73	447	35
36	TOTAL (lines 4 thru 35)				$ 55,368	$ 1,621		$ 2,770	$ 1,149	$ 11,394	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC RENOV.			1998	7,095	182	20	355	173	1,006	9
10	WALLPAPER			1998	2,800	72	20	140	68	397	10
11	PLUMBING REONV.			1998	4,689	120	20	234	114	663	11
12	ELECTRICAL			1998	798	20	20	40	20	113	12
13	PAD DOORS			1998	4,398	113	20	220	107	440	13
14	COVE BASE			1998	577	15	20	29	14	77	14
15	CUBICLE CURTAINER			1998	4,227	108	20	211	103	563	15
16	ELEVATOR RENOV.			1998	4,048	104	20	202	98	606	16
17	CUBICLE CURTAINS			1998	4,651	119	20	233	114	641	17
18	PLUMBING RENOV.			1998	1,024	26	20	51	25	149	18
19	HVAC RENOV			1998	2,530	65	20	127	62	360	19
20	FLOOR RENOV.			1998	12,208	313	20	610	297	1,627	20
21	PLUMBING RENOV.			1998	2,065	53	20	103	50	266	21
22	DRYWALL			1998	2,700	69	20	135	66	349	22
23	HVAC RENOV.			1998	4,565	117	20	228	111	589	23
24	PLUMBING RENOV			1998	5,793	149	20	290	141	846	24
25	WALL A/C			1998	3,041	78	20	152	74	342	25
26	ACROUYN BUMPERS			1998	1,884	48	20	94	46	251	26
27	HVAC RENOV			1998	19,149	491	20	957	466	2,313	27
28	WALLPAPER			1998	3,134	80	20	157	77	419	28
29	HVAC RENOV			1998	4,561	117	20	228	111	532	29
30	ROOF RENOV			1998	21,028	539	20	1,051	512	2,978	30
31	PAINTING/DECOR			1998	3,140	81	20	157	76	379	31
32	FREEZER RENOV			1998	1,011	26	20	51	25	119	32
33	PLUMBING RENOV			1998	7,358	189	20	368	179	889	33
34	PLUMBING			1998	657	17	20	33	16	72	34
35	HVAC RENOV			1998	5,410	139	20	271	132	678	35
36	TOTAL (lines 4 thru 35)				$ 134,541	$ 3,450		$ 6,727	$ 3,277	$ 17,664	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING			1998	1,771	45	20	89	44	208	9
10	PLUMBING RENOV			1998	1,644	42	20	82	40	205	10
11	CUBICLE CURTAINS			1998	18,143	465	20	907	442	2,494	11
12	HVAC RENOV			1998	1,255	32	20	63	31	142	12
13	PLUMBING			1998	944	24	20	47	23	106	13
14	ELECTRICAL			1998	750	19	20	38	19	86	14
15	DOOR			1998	886	23	20	44	21	95	15
16	WALL A/C			1998	3,041	78	20	152	74	329	16
17	HVAC RENOV			1998	2,298	59	20	115	56	249	17
18	HVAC			1998	1,895	49	20	95	46	261	18
19	PLUMBING RENOVATION			1998	512	13	20	26	13	52	19
20	HVAC RENOV.			1998	5,666	145	20	283	138	849	20
21	ELECTRICAL			1998	995	26	20	50	24	125	21
22	WALLPAPER			1998	4,745	122	20	237	115	691	22
23	SMOKE DAMPERS			1998	4,850	124	20	243	119	486	23
24	WALLPAPER			1998	2,135	55	20	107	52	214	24
25	HVAC RENOVATION			1998	5,617	144	20	281	137	492	25
26	HVAC RENOVATION			1998	2,843	73	20	142	69	249	26
27	HVAC RENOVATION			1998	2,512	64	20	126	62	221	27
28	PLUMBING RENOVATION			1998	972	25	20	49	24	86	28
29	PLUMBING RENOVATION			1999	911	23	20	46	23	88	29
30	HVAC RENOVATION			1999	2,149	55	20	107	52	205	30
31	PLUMBING RENOVATION			1999	577	15	20	29	14	58	31
32	FIRE DAMPER			1999	2,750	71	20	138	67	196	32
33	DRYWALL			1999	755	19	20	38	19	76	33
34	ELEVATOR RENOVATION			1999	1,268	33	20	63	30	121	34
35	FAUCET			1999	724	246	20	36	(210)	48	35
36	TOTAL (lines 4 thru 35)				$ 72,608	$ 2,089		$ 3,633	$ 1,544	$ 8,432	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC RENOVATION			1999	900	23	20	45	22	79	9
10	SMOKE DAMPERS			1999	5,840	150	20	292	142	584	10
11	PAINT			1999	3,682	94	20	184	90	276	11
12	PLUMBING RENOVATION			1999	880	23	20	44	21	81	12
13	FIRE ALARM SYSTEM			1999	1,160	30	20	58	28	116	13
14	FIRE ALARM SYSTEM			1999	1,055	27	20	53	26	97	14
15	WIRING			1999	750	19	20	38	19	60	15
16	PLUMBING RENOVATION			1999	1,725	44	20	86	42	136	16
17	ELECTRICAL RENOV.			1999	1,015	26	20	51	25	98	17
18	AC RENOVATION			1999	934	24	20	47	23	94	18
19	ELECTRICAL RENOV.			1999	989	25	20	49	24	90	19
20	HVAC RENOVATION			1999	1,520	39	20	76	37	101	20
21	HVAC RENOVATION			1999	995	26	20	50	24	71	21
22	AIR UNITS			1999	1,520	39	20	76	37	108	22
23	HVAC			1999	640	16	20	32	16	45	23
24	HVAC RENOVATION			1999	518	13	20	26	13	35	24
25	HVAC RENOVATION			1999	1,685	43	20	84	41	112	25
26	HVAC			1999	1,520	39	20	76	37	95	26
27	AIR UNITS			1999	1,520	39	20	76	37	108	27
28	FIRE DAMPER			1999	2,750	71	20	138	67	173	28
29	SECURITY SYSTEM			1999	977	332	20	49	(283)	69	29
30	HVAC			1999	1,685	43	20	84	41	105	30
31	REPLACE FAUCETS			1999	597	15	20	30	15	38	31
32	HOT WATER LINE			1999	898	23	20	45	22	56	32
33	PIPE TRAPS			1999	822	21	20	41	20	51	33
34	HVAC RENOVATION			1999	1,685	43	20	84	41	98	34
35	A/C RENOV			1999	1,685	43	20	84	41	91	35
36	TOTAL (lines 4 thru 35)				$ 39,947	$ 1,330		$ 1,998	$ 668	$ 3,067	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING RENOV			1999	850	22	20	43	21	47	9
10	TELEPHONE SYSTEM			1999	13,242	5,032	20	662	(4,370)	717	10
11	HVAC RENOVATION			1999	1,520	39	20	76	37	101	11
12	PANIC DEVICE			2000	576	115	20	44	(71)	44	12
13	WALL A/C UNITS			2000	1,685	38	20	77	39	77	13
14	CONDENSOR RENOV			2000	875	19	20	40	21	40	14
15	PLUMBING RENOV			2000	903	20	20	41	21	41	15
16	ELECTRIC WIRING			2000	600	2	20	5	3	5	16
17	LABELS FOR BOILER			2000	1,137	6	20	14	8	14	17
18	A/C REPAIR			2000	505	1	20	2	1	2	18
19	DOORS			2000	955	5	20	12	7	12	19
20	INDUSTRIAL MOTOR			2000	528	106	20	44	(62)	44	20
21	DOORS			2000	1,425	17	20	36	19	36	21
22	PAINT			2000	888	12	20	26	14	26	22
23	PLUMBING REPAIR			2000	3,071	43	20	90	47	90	23
24	REPLACE A/C			2000	3,478	696	20	203	(493)	203	24
25	AC REPAIR			2000	574	115	20	33	(82)	33	25
26	BOILER RENOV			2000	516	103	20	39	(64)	39	26
27	DOORS			2000	1,980	23	20	50	27	50	27
28	AC WORK			2000	3,478	41	20	87	46	87	28
29	DOORS			2000	1,600	19	20	40	21	40	29
30	WIRING			2000	585	7	20	15	8	15	30
31	AC WORK			2000	3,478	696	20	145	(551)	145	31
32	ZONE VALVE			2000	507	102	20	47	(55)	47	32
33	AC WORK			2000	687	138	20	29	(109)	29	33
34	AC WORK			2000	2,640	528	20	110	(418)	110	34
35	AC WORK			2000	598	120	20	25	(95)	25	35
36	TOTAL (lines 4 thru 35)				$ 48,881	$ 8,065		$ 2,035	$ (6,030)	$ 2,119	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MASONRY RESTORATION			2000	1,435	14	20	30	16	30	9
10	AC WORK			2000	1,827	22	20	46	24	46	10
11	AC WORK			2000	3,478	41	20	87	46	87	11
12	AC WORK			2000	4,521	904	20	188	(716)	188	12
13	A/C REPAIR			2000	814	1	20	3	2	3	13
14	TOILET REPAIR			2000	522	1	20	2	1	2	14
15	AC WORK			2000	1,479	296	20	49	(247)	49	15
16	LOUNGE ROOM IN BSMNT			2000	2,300	2	20	10	8	10	16
17	PAINT			2000	2,236	2	20	9	7	9	17
18	ARCHITECT FEES			2000	729	1	20	3	2	3	18
19	FIRE ALARM, SPRINKLE			2000	184,600	2,169	20	4,615	2,446	4,615	19
20	A/C REPAIR			2000	551	1	20	2	1	2	20
21	BOILER INSULATION			2000	1,131	226	20	94	(132)	94	21
22	PLUMBING			2000	1,443	17	20	36	19	36	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 207,066	$ 3,697		$ 5,174	$ 1,477	$ 5,174	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996	Alloc - CCI	$ 33,265	$ 853	35	$ 950	$ 97	$ 3,881	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fairview Health Care Properties			1995	1,888	48	39	48		278	9
10											10
11	Care Center allocation			2000	40	1	20	2	1	2	11
12	Care Center allocation			1999	596	15	20	30	15	56	12
13	Care Center allocation			1998	246	6	20	12	6	33	13
14	Care Center allocation			1997	3,489	80	20	192	112	932	14
15	Care Center allocation			1996	3,835	51	20	184	133	633	15
16	Care Center allocation			1997	405	94	20	17	(77)	40	16
17	Care Center allocation			1994		11	20		(11)		17
18	Care Center allocation			1993		3	20		(3)		18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 43,764	$ 1,162		$ 1,435	$ 273	$ 5,855	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 561,420	$ 59,940	$ 56,568	$ (3,372)		$ 433,752	37
38	Current Year Purchases	33,530	6,633	2,465	(4,168)		2,465	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 594,950	$ 66,573	$ 59,033	$ (7,540)		$ 436,217	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Care Center Allocation			$ 15,801	$ 3,423	$ 2,437	$ (986)	10	$ 5,470	42
43										43
44										44
45										45
46	TOTALS			$ 15,801	$ 3,423	$ 2,437	$ (986)		$ 5,470	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,076,659	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 209,551	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 206,817	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (2,734)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,279,050	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

FAIRVIEW NURSING HOME, INC.
0038745
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Fairview Nursing Home	156,848	22,407	15,882	(6,525)	59,795
Fairview Health Care Properties	376,361	33,883	37,636	3,753	360,879
Care Center, Inc.	28,211	3,650	3,050	(600)	13,078
TOTALS	561,420	59,940	56,568	(3,372)	433,752
LINE 29: CURRENT YEAR					
Fairview Nursing Home	31,941	6,360	2,428	(3,932)	2,428
Fairview Health Care Properties					
Care Center, Inc.	1,589	273	37	(236)	37
TOTALS	33,530	6,633	2,465	(4,168)	2,465
LINE 30: FULLY DEPRECIATED					
Fairview Nursing Home					
Fairview Health Care Properties					
Care Center, Inc.					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
Fairview Nursing Home	188,789	28,767	18,310	(10,457)	62,223
Fairview Health Care Properties	376,361	33,883	37,636	3,753	360,879
Care Center, Inc.	29,800	3,923	3,087	(836)	13,115
TOTALS	594,950	66,573	59,033	(7,540)	436,217

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	CareCenter Allocation				3,133			5
6								6
7	TOTAL				$ 3,133 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 11,486 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 84,841	$		$ 84,841	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,463			6,463	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			102,677			102,677	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				77,527		77,527	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1		666					666	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					47,272		47,272	13
14	TOTAL			$ 666		$ 193,981	$ 124,799		$ 319,446	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	21,419
2	Air-Fluidized Beds	13,831
3	Oxygen	3,884
4	Equipment Rental	
5	Respiratory Therapy Supplies	357
6	Radiology	2,562
7	Enterals	3,566
8	Laboratory	1,653
9		
10		
		47,272

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 56,295	$ 81,694	1
2	Cash-Patient Deposits	39,131	39,131	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	897,402	899,360	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	174,292	174,292	6
7	Other Prepaid Expenses	4,315	4,315	7
8	Accounts Receivable (owners or related parties)	442,329	477,084	8
9	Other(specify): See supplemental schedule	85,495	97,735	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,699,259	$ 1,773,611	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		321,372	13
14	Buildings, at Historical Cost		4,323,143	14
15	Leasehold Improvements, at Historical Cos	711,773	713,661	15
16	Equipment, at Historical Cost	252,759	629,120	16
17	Accumulated Depreciation (book methods)	(209,709)	(1,294,550)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		114,911	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(48,803)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,918	1,918	22
23	Other(specify): See supplemental schedule	10,998	10,998	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 767,739	$ 4,771,769	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,466,998	$ 6,545,381	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 581,021	$ 581,021	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,691	37,691	28
29	Short-Term Notes Payable	1,468,128	1,468,128	29
30	Accrued Salaries Payable	195,988	195,988	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,330	12,330	31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,399	192,137	32
33	Accrued Interest Payable		27,381	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(20,300)	(20,300)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,463,257	$ 2,494,376	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,550,261	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,550,261	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,463,257	$ 8,044,637	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,741	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,466,998	$ #REF!	48

*(See instructions.)

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	85,495	85,495
Engineering Escrow		12,240
	85,495	97,735

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Capital Expend. Res.	10,998	10,998
	10,998	10,998

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 402,368	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 402,368	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(398,627)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (398,627)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,741	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	FAIRVIEW NURSING HOME, INC.	#	0038745	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		402,368
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		402,368
Equity(Deficit) from Page 17 Col 1		3,741
Related Party		
Equity(Deficit)	-1429339	
Income	-73657.67	
		(1,502,997)
Combined Equity - End of Year		(1,499,256)

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,359,498	1
2	Discounts and Allowances for all Levels	(808,522)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,550,976	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	712,852	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 712,852	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	368	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,996	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,094	19
20	Radiology and X-Ray	2,156	20
21	Other Medical Services	93,038	21
22	Laundry	899	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 199,551	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43,349	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43,349	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,813	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,813	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,509,541	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,018,205	31
32	Health Care	2,268,909	32
33	General Administration	1,284,139	33
	B. Capital Expense		
34	Ownership	945,549	34
	C. Ancillary Expense		
35	Special Cost Centers	319,447	35
36	Provider Participation Fee	71,919	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,908,168	40
41	**Income before Income Taxes (line 30 minus line 40)****	(398,627)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (398,627)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **FAIRVIEW NURSING HOME, INC** **# 0038745** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION		AMOUNT
1	Jury Duty Income	(adjusted out on page 5)	155
2	Misc. Income	(adjusted out on page 5)	100
3	Wheelchair Income		2,558
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
		TOTALS	2,813

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,103	$ 62,750	$ 29.84	1
2	Assistant Director of Nursing	1,920	2,159	57,070	26.43	2
3	Registered Nurses	16,060	18,838	383,662	20.37	3
4	Licensed Practical Nurses	17,629	21,505	426,254	19.82	4
5	Nurse Aides & Orderlies	64,731	77,170	726,281	9.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	37	37	666	18.00	7
8	Rehab/Therapy Aides	4,379	5,375	75,991	14.14	8
9	Activity Director	1,723	2,019	24,660	12.21	9
10	Activity Assistants	7,684	8,685	69,425	7.99	10
11	Social Service Workers	3,489	4,034	52,441	13.00	11
12	Dietician					12
13	Food Service Supervisor	2,684	3,049	34,392	11.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,517	19,102	154,366	8.08	15
16	Dishwashers					16
17	Maintenance Workers	3,696	4,215	52,665	12.49	17
18	Housekeepers	22,294	24,810	217,153	8.75	18
19	Laundry	8,017	8,858	76,354	8.62	19
20	Administrator	1,016	1,139	27,385	24.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,843	9,306	111,047	11.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,888	2,478	42,418	17.12	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	183,551	214,882	$ 2,594,980 *	$ 12.08	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	261/monthly	$ 14,852	1-3	35
36	Medical Director	monthly	12,000	9-3	36
37	Medical Records Consultant	monthly	674	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,760	10-3	39
40	Physical Therapy Consultant	72	3,613	10A-3	40
41	Occupational Therapy Consultant	40	2,013	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,224	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI costs	see attached	22,504		48
49	TOTAL (lines 35 - 48)	161	$ 61,640		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 568	10-3	50
51	Licensed Practical Nurses	356	9,252	10-3	51
52	Nurse Aides	12,642	204,924	10-3	52
53	TOTAL (lines 50 - 52)	13,014	$ 214,744		53

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Wulf	Administrator	0	$ 27,385
Additional Administrative salaries directly allocated from Care Center (see page 6)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 27,385

B. Administrative - Other

Description	Amount
Chris Wayer - Management Fee	$ 6,175
Administrative payroll (adjusted on page 6)	34,006
TOTAL (agree to Schedule V, line 17, col. 3)	$ 40,181
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Keane & Keane	RE Tax Appeal	$ 15,000
Frost, Ruttenberg, & Rothblatt	Accounting	9,383
Alpha Data Services	Computer Services	4,253
Source Tech	Computer Services	805
Maxxsource	Dietary Software	500
Care Centers, Inc.	various - see attached	191,235
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 221,176

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,243
Unemployment Compensation Insurance	25,030
FICA Taxes	191,055
Employee Health Insurance	93,096
Employee Meals	21,338
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	20,348
Employee Physicals	140
Misc. Employee Welfare	3,326
Christmas Expense	2,164
TOTAL (agree to Schedule V, line 22, col.8)	$ 432,740

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	31,664
Health Care Worker Background Check	1,566
(Indicate # of checks performed 130)	
Dues & Subscriptions	6,506
License & Fees	14,063
Yellow Page Advertising	2,216
Advertising & Promotion	10,917
Placement Fee	2,640
Allocated from Care Center	989
Less: Public Relations Expense	( )
Non-allowable advertising	(10,917)
Yellow page advertising	(2,216)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,828

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,071
Educational Materials - Handbooks	1,699
Allocation from Care Center	3,510
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,280

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIRVIEW NURSING HOME, INC. # 0038745 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Council on Long Term Care $3828

(3) Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,654 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ 71,919
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ 21,338 Has any meal income been offset against related costs? YES Indicate the amount. $ 368

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 1
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report?
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Frost, Ruttenberg & Rothblatt The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw